

**Heart of Florida Health Center**

**2553 EAST SILVER SPRINGS BLVD**

**OCALA, FL 34470**

**352.732.6599**

Name of Minor Child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent/Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization for Treatment of Minor Child**

I give consent for Heart of Florida Health Center to examine and provide necessary treatment to the above-named minor child, including but not limited to: Screenings, diagnostic tests, prescription medications, and referrals to specialists or other health care providers. This consent applies to the following services (**initial all that apply**):

\_\_\_\_\_ Medical evaluation and treatment

\_\_\_\_\_ Dental evaluation and treatment

\_\_\_\_\_ Behavioral health assessment and treatment

\_\_\_\_\_ I agree that HFHC may provide the services I have initialed with my verbal consent, in compliance with applicable law and HFHC policies.

\_\_\_\_\_ I acknowledge that by filling prescriptions or requesting medication refills, I am consenting to the prescribing of the medication or treatment as deemed medically necessary by the ordering provider.

I authorize the following persons to accompany the minor child to appointments **and to consent** to treatment or services in my absence, as permitted by Florida statutes 743.0645 (2)(a).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name Relationship to child

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Name Relationship to child

The following persons may accompany the child to appointments but are **NOT** authorized to consent to services for the minor child.

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 Name Relationship to child

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 Name Relationship to child

This consent remains valid unless revoked in writing. I understand that I may revoke this consent at any time by providing written notice to HFHC. Revocation will not affect any action taken in reliance on this authorization prior to receiving written notice of revocation.

**Signature MUST be notarized if not signed in the presence of HFHC staff**

Signature of Parent/Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness or Notary Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness/Notary Name (printed)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_